PRINTED: 10/28/2016 FORM APPROVED

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
7.1.12 . 2.1.1		1521111110/111011110/11152111	A. BUILDING: _						
		N046042	B. WING		10/24/2016				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
BICKFOR	BICKFORD AT MISSION SPRINGS I 5300 W 61ST PLACE MISSION, KS 66205								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE			
S 000	INITIAL COMMENTS		S 000						
	resurvey at the above	s represent the findings of a named assisted living 10-20-16 and 10-24-16							
S3299 SS=E	299 26-41-206 (e) (1) Facility Food Storage		S3299						
	under safe and sanita (1) Containers of cleaning supplies sha	cility staff shall store all food ary conditions. poisonous compounds and all not be stored in the areas preparation, or serving.							
	This REQUIREMENT by: KAR 26-41-206(e)(1)	is not met as evidenced							
	The sample included review residents. Barinterview for all residents.	a census of 37 residents. 3 residents and two focus sed on observation and ents, the operator failed to hall store all food under safe hs.							
	Findings included:								
	10-20-16 at 9:30 a.m. No thermometer inside from dining room while condiments. Upright freezer with lainside on shelving and Three large plastic concernals lacked labels, were sticky with food	ontainers of repackaged /dates when filled and tops							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		N046042	B. WING		10/24/2016	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1	
BICKFOR	D AT MISSION SPRINGS	5300 W 61S MISSION, K				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S3299	cheeses which lacked (operator removed). cheese lacked label/d of white substances la unsure what they con Upright freezer in bac frozen vegetables lac thermometer. At the end of the islar containing flour and s sticky and discolored - Observation on 10-freezer on memory cathermometer (removed Facility policy for "Din the policy for the Foodwrap, label, date and appropriate manner. illness and retain foodstale or dried out. Profoods, pre-packaged protein-based salads dated and securely cobe written on the cont date it was opened or are prepared at the bithe end of the third da until the expiration da manufacture."  Interview with operator and 10:35 a.m. confinobservations; remove items. Confirmed the policy.	containers of shredded dilabel/dates when filled Plastic container of sliced date. Two plastic containers acked label/date (operator stained and removed). Sk hall which was filled with ked an internal and, were two large bins augar with tops that were with food debris.  20-16 at 10:35 a.m. of small are unit contained an oven ed by operator).  Ining Service" stated: "It is discovered all foods in a safe, This is to prevent foodborned quality from becoming ocedure: 1) All cooked open containers, and desserts are labeled, overed2) All dates are to tainer and represent the prepared. All foods that tranch must be discarded at ay. Other foods may be kept the listed by the	S3299			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		N046042	B. WING		10	0/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
DIOKEOD	D AT MICCION CRRINGS	5300 W 6	S1ST PLACE				
BICKFOR	D AT MISSION SPRINGS	MISSION	I, KS 66205				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S3299	Continued From page	· 2 ure facility staff stored all	\$3299				